

FY 2016 Flex Grant

APPLICATION GUIDANCE

Release Date: September 12, 2016

Application Deadline:

October 17, 2016 at 5:00 PM Mountain Time

BUREAU OF RURAL HEALTH & PRIMARY CARE
DIVISION OF PUBLIC HEALTH
DEPARTMENT OF HEALTH AND WELFARE

Technical Assistance Webinar: September 16, 2016 at 10:00 AM Mountain Time

<https://attendee.gotowebinar.com/register/2408366248566931714>

Applications **must be received** by no later than Monday, October 17, 2016, 5:00 PM Mountain Time. Late applications will not be reviewed. Applications may be submitted via post, delivery, or email.

Submit applications to:

Bureau of Rural Health & Primary Care
450 W. State Street- 4th floor
P.O. Box 83720
Boise, Idaho 83720-0036
Email: sayeghs@dhw.idaho.gov



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I. Purpose of the Medicare Rural Hospital Flexibility Program (Flex)

The Medicare Rural Hospital Flexibility Program (Flex) was established by the Balanced Budget Act of 1997. The purpose of the Medicare Rural Hospital Flexibility Grant (Flex) Program is providing support for critical access hospitals (CAHs) to encourage quality and performance improvement activities including: stabilizing rural hospital finance, integrating emergency medical services (EMS) into their health care systems, incorporating population health, and fostering innovative models of health care.

The overall goals of the Flex program related to this grant opportunity are:

- Improve the quality of care provided by CAHs.
- Improve the financial and operational outcomes of CAHs.
- Support the financial and operational transition to value based models and healthcare transformation models in the healthcare system.

The Bureau of Rural Health & Primary Care receives federal funds to support Flex Program activities to ensure residents in rural communities have continued access to high quality health care services. Grants made available through this program must support Flex program goals.

II. Eligibility Information

A. Eligible Applicants

- Cohort of designated Idaho CAHs (two or more CAHs working together formally or informally)
 - One (1) CAH must be the lead applicant
- Idaho rural health networks (must be nonprofit and include at least two Idaho CAHs)
- An individual Idaho CAH without a cohort may only apply for the Innovative/Transformative Healthcare Model opportunity
- Those entities awarded last year (FY15) cannot apply for the same focus area this year (FY16). For example, if awarded the Quality Improvement cohort last year, the entity could only apply for a Financial and Operational cohort or Innovative/Transformative Health Model.

B. Eligible Activities

- **Quality Improvement:** Projects/activities connected to the improvement of Medicare Beneficiary Quality Improvement Project (MBQIP) required and additional measures ([see Appendix A](#))
- **Financial and Operational Improvement:** Projects/activities to improve the 10 financial/operational indicators identified in the Critical Access Hospital Finance 101 Manual ([see Appendix B](#))
- **Innovative/Transformative Healthcare Model:** Projects/activities to support specific efforts targeting clinically integrated networks, Population Health Management, projects addressing frequent/high cost users of health care or emergency department, care coordination, etc. ([see Appendix C](#))

Projects must be data-driven and include well-defined performance goals and outcomes. All CAH cohorts will be required to establish baseline data and targets:

- Quality Improvement Data: MBQIP, CMS Hospital Compare, National Healthcare Safety Network, Hospital Engagement Network, etc.
- Finance/Operations Data: Flex Monitoring Team (FMT)
- Innovative/Transformative Healthcare Model: Applicants must identify specific outcome measures related to the innovative/transformational project activities.

Funds **cannot** subsidize activities that are a routine part of doing business as a CAH. Examples include, but are not limited to: replacement of routine supplies, preparation for routine surveys or licensure, etc. Food costs cannot be included in the request for grant funding.

III. Grant Specifics

A. Requirements

Application Requirements: Projects must be focused on improving healthcare quality, financial and operational performance, or implementing an innovative healthcare model. Idaho CAHs must work together in a cohort (with the exception of the Innovative/Transformative Healthcare Model opportunity).

Reporting Requirements: A **report** of activities and expenditures will be due no later than August 31, 2017, along with all invoices requesting reimbursement. Although there is no funding for the second year, a **final report** summarizing activities, data-related metrics, and outcomes will be due no later August 31, 2018.

By applying, the lead applicant acknowledges the following statements:

- No entity, as defined at 2 CFR Part 25, Subpart C, may receive award of a subgrant unless the entity has provided its DUNS number. (2 CFR 25.110)
- Subgrantees spending \$750,000.00 or more in federal funds during the Subgrantee's fiscal year shall have a Single Audit performed according to 2 CFR 200.500-521 (previously OMB A-133) and shall provide proof of spending.
- The entity shall comply with subaward and executive compensation reporting requirements, as required by the Federal Funding Accountability and Transparency Act (FFATA).

B. Award Amounts

- Quality Improvement Cohort: 2 awards of \$26,500 each
- Financial/Operational Improvement Cohort: 2 awards of \$26,500 each
- Innovation/Transformation Model: 1 award of \$20,000

C. Duration of Funding

November 14, 2016* through August 31, 2017. Projects and expenditures must be completed and incurred during this timeframe. Reporting will continue through August 31, 2018 to demonstrate outcomes.

D. Timeline

Applications Available: September 12, 2016

Technical Assistance Webinar: September 16, 2016 @ 10:00 AM (MT)

Applications Due: October 17, 2016 at 5:00 PM Mountain Time/4:00 PM Pacific Time

Award Notification: No later than November 10, 2016

Subgrant Start Date: November 18, 2016 (approximate)*

*The subgrant is effective on the date all necessary signatures are obtained. Therefore, activities funded by this grant award may not occur until after the subgrant is established.

E. Award Process

Applications are reviewed and awarded by the state Flex Advisory Committee. Once an award decision has been made, a subgrant document will be sent to the applicant for review and signature. This subgrant must be sent back to Contracting and Procurement Services Unit (CAPSU), Idaho Department of Health and Welfare. When the subgrant is fully executed, a signed original will be returned to the applicant. Activities cannot be initiated until the subgrant is signed and established.

IV. Application and Submission Information

A. Application Format Requirements

Applications are limited to 5 ½ pages. Appendices are excluded from the page limit. Applications that exceed the page limit will not be reviewed.

Submit one (1) original copy of your application on 8 1/2" X 11" white paper. Margins must be at least one (1) inch at the top, bottom, left and right sides. Please left-align text and 1.0 line spacing. Font size should be Calibri 12, Times New Roman 12, or Arial 11.

Pages must be numbered consecutively from the Project Summary through the appendices. Handwritten numbering is acceptable.

Please do **not** bind or staple the application if you choose to submit a hard copy.

Contact the Bureau of Rural Health & Primary Care at (208) 334-0669 for questions and assistance regarding the application and submission process.

B. Components of an Application

A completed application will include these components in the following order:

- i. Application Face Page
- ii. Table of Contents
- iii. Project Summary
- iv. Background Information
- v. Statement of Need
- vi. Scope of Work
- vii. Work Plan
- viii. Evaluation
- ix. Grant Budget
- x. Appendices
 - A. Letters of support from project partners, if applicable
 - B. Additional budget information, if applicable

C. Specific Application Instructions

i. Application Face Page

The face page is found on page 9 of this application packet. All fields **must** be completed and signed as indicated.

ii. Table of Contents

To facilitate evaluation, applicants should include a Table of Contents which reflects the major sections of the application including the page numbers on which they can be found.

iii. Project Summary (limit ½ page)

Please provide a brief summary which concisely states the following:

- a) Identify the applicant organization, other CAH project partners, and the area of the state the project will serve.
- b) Identify the Flex program goal your project will address and how your project supports the identified goal. (*see page 3 for Flex program goals*)
- c) Describe the activities your project will undertake. Include the baseline data (MBQIP, FMT, etc.) driving your project and the anticipated outcomes.

iv. Background Information (limit ½ page)

- a) Provide a description of the CAHs involved in the cohort (*Innovative/Transformative Model is the exception*).
- b) Provide a description of partners and other agencies collaborating on the project, if applicable.

v. Statement of Need (limit ½ page)

Describe the issue the application seeks to address. Use current clinical, financial, operational performance or demographic data and other background sources or information in the description, as available and appropriate. Describe how you know your project is needed in the proposed community, agency or facility, and the lack of available funding from other resources.

vi. Scope of Work (limit ½ page)

- a) Provide a detailed description of the project. Include the baseline data used to develop your project.
- b) Describe the community or population to be served by the project.
- c) Describe how the benefits of your proposed project or the project itself will be sustained beyond the grant funding period.

vii. Work Plan (limit 1 page)

- a) Must be in table form.
- b) Include the following elements: measurable project objectives, methods/activities to achieve stated objectives, timeline for completion, and cost.

viii. Evaluation (limit 1 page)

All applications will need to provide baseline data, targets and anticipated measurable outcomes. Within this section, describe the anticipated project outcome, including

changes to the baseline data (MBQIP additional measures, Critical Access Hospital Finance 101 Manual measures, etc.). For each objective in your work plan, there should be a corresponding method of evaluating outcomes. The evaluation should be in table form.

ix. Grant Budget (limit 1 ½ pages, including table)

All reasonable costs of conducting identified activities are eligible. **The following federal prohibitions apply: construction, renovation, modernization, routine hospital and emergency medical services, operating costs, food, or individual clinical services. No more than forty percent (40%) of grant funds may be used for equipment.**

- The total amount requested cannot exceed
 - a) \$26,500 Quality Cohort; or
 - b) \$26,500 Financial/Operational Cohort; or
 - c) \$20,000 Innovation/transformation model.
- If applicable, indicate other funding sources that will also be used to support the proposed project.
- Indirect costs cannot exceed the ten percent (10%) de minimis rate of the total award.
- **The purchase of equipment may not represent more than forty percent (40%) of the total annual share of the proposal.**
- The grant begins in November 2016 and funds must be expended no later than August 31, 2017, reporting will end August 31, 2018.
 - a) Create an itemized budget table for your proposed budget. Identify funds allocated to all CAHs directly involved in the project (if applicable).
 - b) Provide a detailed budget justification narrative to support your proposed budget. The narrative may include the following expenses as requested in your proposal: personnel, travel, equipment, supplies, operating, and contractual agreements.
 - c) All proposed equipment purchases require one (1) or more vendor price quotes. This documentation should be included as Appendix B of your application.

x. Appendices (no page limit on this section)

- A. Letters of support from CAHs and partners directly involved in the project are strongly encouraged.
- B. Additional budget information, if applicable:
 - a) Vendor price quotes for proposed equipment purchases.

D. Submission Requirements

Applications must be **received** by the Bureau of Rural Health & Primary Care no later than: **Monday, October 17, 2016, 5:00 PM Mountain Time/4:00 PM Pacific Time.**

Applications may be submitted by post, delivery, or email. **Applicants submitting via email must include a face page that is signed and scanned.** It is strongly encouraged you contact the office to confirm receipt of your submission.

Address: Bureau of Rural Health & Primary Care
450 W. State St. – 4th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-0669
Email: sayeghs@dhw.idaho.gov

Only **one** application will be accepted from each eligible lead applicant. However, CAHs can participate in more than one cohort.

Each applicant will receive notification verifying receipt of the application. All applicants will be notified of the status of their application by November 10, 2016.

V. Application Evaluation and Award Criteria

The Flex Advisory Committee will meet and review all grant submissions based on the following criteria:

Applications will be scored on a 100 point scale, summarized as follows:

- The extent to which the project addresses **one** of the following goals of Idaho's Medicare Rural Hospital Flexibility Program (20 points maximum). These include:
 - Improve the quality of care provided by CAHs as measured in the MBQIP additional metrics.
 - Improve the financial and operational outcomes of CAHs as measured by the 10 indicators presented in the Critical Access Hospital Finance 101 Manual.
 - Support the financial and operational transition to value based models and health care transformation models in the health care system.
- A clear description of the context and need for the grant project. (20 points maximum)
- A reasonable work plan indicating the likelihood of a successful outcome of the proposed project. (15 points maximum)
- The proposal includes baseline data, well-defined performance goals and measureable outcomes. (30 points maximum)
- A clear and realistic budget for the proposed project. (15 points maximum)

VI. Application Face Page

Medicare Rural Hospital Flexibility (Flex) Grant

Lead Applicant organization:

Federal tax identification number (TIN):

Data Universal Numbering System (DUNS):

Idaho CAHs participating in cohort (required for Quality or Finance):

Other partner or collaborating organizations (if applicable):

Name of contact person:

Phone number: Fax number:

Address:

City & zip code: E-mail:

Amount of funding requested:

Brief project description:

Flex program goal addressed by this proposal (check all that apply):

☐ Support CAH quality improvement efforts as related to the Medicare Beneficiary Quality Improvement Project additional goals (*CAH Cohort*).

☐ Support CAH operational and financial improvement efforts as related to the 10 indicators presented in the Critical Access Hospital Finance 101 Manual (*CAH Cohort*).

☐ Support the financial and operational transition to value based models and health care transformation models in the health care system (*Cohort not required*).

I hereby certify that the information contained in this application is true and correct. All funds determined to have been acquired on the basis of fraudulent information must be returned to the Medicare Rural Hospital Flexibility Program.

Authorized signature: _____ Date:

Printed name and title:



IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

VII. Appendix A

Medicare Beneficiary Quality Improvement Data Table

Medicare Beneficiary Quality Improvement Project (MBQIP) Measures

	Patient Safety	Patient Engagement	Care Transitions	Outpatient
Core Improvement Initiatives	<p>OP-27: Influenza Vaccination Coverage Among Healthcare Personnel (HCP) <i>(Facilities report a single rate for inpatient and outpatient settings)</i></p> <p>IMM-2: Influenza Immunization</p>	<p>Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)</p> <p><i>The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass nine key topics:</i></p> <ul style="list-style-type: none"> • Communication with Doctors • Communication with Nurses • Responsiveness of Hospital Staff • Pain Management • Communication about Medicines • Discharge Information • Cleanliness of the Hospital Environment • Quietness of the Hospital Environment • Transition of Care <p><i>The survey also includes four screener questions and seven demographic items. The survey is 32 questions in length.</i></p>	<p>Emergency Department Transfer Communication (EDTC)</p> <p><i>7 sub-measures; 27 data elements; 1 composite</i></p> <ul style="list-style-type: none"> • EDTC-1: Administrative Communication (2 data elements) • EDTC-2: Patient Information (6 data elements) • EDTC-3: Vital Signs (6 data elements) • EDTC-4: Medication Information (3 data elements) • EDTC-5: Physician or Practitioner Generated Information (2 data elements) • EDTC-6: Nurse Generated Information (6 data elements) • EDTC-7: Procedures and Tests (2 data elements) • All-EDTC: Composite of All 27 data elements 	<p>OP-1: Median Time to Fibrinolysis</p> <p>OP-2: Fibrinolytic Therapy Received within 30 minutes</p> <p>OP-3: Median Time to Transfer to another Facility for Acute Coronary Intervention</p> <p>OP-4: Aspirin at Arrival</p> <p>OP-5: Median Time to ECG</p> <p>OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients</p> <p>OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional</p> <p>OP-21: Median Time to Pain Management for Long Bone Fracture</p> <p>OP-22: Patient Left Without Being Seen</p>

Medicare Beneficiary Quality Improvement Project (MBQIP) Measures

	Patient Safety	Patient Engagement	Care Transitions	Outpatient
Additional Improvement Initiatives	<p>Healthcare Acquired Infections (HAI)</p> <ul style="list-style-type: none"> • CLABSI: Central Line-Associated Bloodstream Infection • CAUTI: Catheter-Associated Urinary Tract Infection • C. diff: <i>Clostridium difficile</i> Infection • MRSA: Methicillin-resistant <i>Staphylococcus aureus</i> <p>Perinatal Care</p> <ul style="list-style-type: none"> • PC-01: Elective Delivery <p>Pneumonia</p> <p>Proportion of patients hospitalized with Pneumonia – potentially avoidable complications</p> <p>Falls</p> <p>Potential measurement around:</p> <ul style="list-style-type: none"> • Falls with Injury • Patient Fall Rate • Screening for Future Fall Risk <p>Adverse Drug Events (ADE)</p> <p>Potential measurement around:</p> <ul style="list-style-type: none"> • Opioids • Glycemic Control • Anticoagulant Therapy <p>Patient Safety Culture Survey</p>		<p>Discharge Planning</p> <p><i>Potential measurement TBD with FORHP</i></p> <p>Medication Reconciliation</p> <p><i>Potential measurement TBD with FORHP</i></p>	<p>ED Throughput</p> <ul style="list-style-type: none"> • ED-1: Median Time from ED Arrival to ED Departure for Admitted ED Patients • ED-2: Admit Decision Time to ED Departure Time for Admitted Patients <p>Stroke</p> <ul style="list-style-type: none"> • OP-23: ED – Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival <p>Surgery/Surgical Care</p> <ul style="list-style-type: none"> • OP-25: Safe Surgery Checklist Use

Medicare Beneficiary Quality Improvement Project (MBQIP) Measures

	<i>Patient Safety</i>	<i>Patient Engagement</i>	<i>Care Transitions</i>	<i>Outpatient</i>
Additional Improvement Initiatives	<p>Reducing Readmissions <i>(These measures are automatically calculated for hospitals using Medicare Administrative Claims Data)</i></p> <p>Stroke</p> <ul style="list-style-type: none"> • STK-1, STK-8 All retired by the Centers for Medicare & Medicaid Services (CMS) as of 1/1/2016 • Proportion of patients hospitalized with Stroke – potentially avoidable complications <p>Venous Thromboembolism (VTE)</p> <ul style="list-style-type: none"> • VTE-1, VTE-2, VTE-3 All retired by the Centers for Medicare & Medicaid Services (CMS) as of 1/1/2016 			

VIII. Appendix B

Critical Access Hospital Finance 101 Manual

Critical Access Hospital Finance 101

Updated October 2015



NATIONAL
RURAL HEALTH
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PURPOSE

This manual was developed for use by state Medicare Rural Hospital Flexibility (Flex) Program personnel as well as staff and boards of critical access hospitals (CAHs). The content is designed to be as non-technical as possible and to provide answers to frequently asked questions regarding CAH finance and financial performance.

GOVERNMENT INSURANCE PROGRAMS

What is Medicare?

The Medicare program, an amendment to Social Security legislation known as Title XVIII, provides medical coverage to all Americans 65 years of age and older. The bill was signed into law by President Lyndon B. Johnson in 1965 and took effect in July, 1966. The enactment of the Medicare program was significant because it was the beginning of the federal government's role as a major financer of health care. In 2010, there were 46.6 million enrollees in the Medicare program, or approximately 15% of the total U.S. population. Approximately 21% of Medicare beneficiaries live in rural counties, meaning rural hospitals tend to have a higher percentage of Medicare recipients than their urban counterparts.

Medicare is health insurance for people 65 or older, people under 65 with certain disabilities and people of any age with End-Stage Renal Disease. Medicare is funded by both Social Security payroll taxes and insurance premiums, with coverage categories divided into "Parts." Medicare Part A is the hospital insurance portion of the program and includes acute hospital inpatient care and inpatient skilled nursing care. Medicare Part B is the medical insurance component and includes coverage for doctor visits and outpatient care. Medicare Part C, known as Medicare Advantage, covers both Part A and Part B options. And, Medicare Part D is the prescription drug coverage component of the program, which went into effect on January 1, 2006.

Medicare Part A (Hospital Insurance)

- Helps cover inpatient care in hospitals, skilled nursing facilities, hospice and home health care
- Most people do not have to pay a premium for Medicare Part A because they, or a spouse, paid Medicare taxes while working in the

United States. If they do not automatically get premium-free Part A, they may still be able to enroll and pay a premium

Medicare Part B (Medical Insurance)

- Helps cover doctors' and other health care providers' services, outpatient care, durable medical equipment and home health care
- Helps cover some preventive services
- Most people pay up to the standard monthly Medicare Part B premium
- Some Medicare recipients buy coverage that fills gaps in Medicare coverage, such as Medicare Supplemental Insurance (Medigap)

Medicare Part C (also known as Medicare Advantage)

- Offers health plan options run by Medicare-approved private insurance companies. Medicare Advantage Plans are a way to get the benefits and services covered under Part A and Part B
- Most Medicare Advantage Plans cover Medicare prescription drug coverage (Part D)
- Some Medicare Advantage Plans may include additional benefits for an additional cost

Medicare Part D (Medicare Prescription Drug Coverage)

- Helps cover the cost of prescription drugs
- May help lower your prescription drug costs and help protect against higher costs
- Run by Medicare-approved private insurance companies
- Costs and benefits vary by plan

What is Medicaid?

Medicaid is health coverage available to people and families who have limited income and resources. It is funded both by the federal government and state governments, but is managed at the state level. The program was enacted in 1965 as Title XIX of the Social Security Act. The funding of Medicaid is a major component of state spending, on average comprising 25% of the total state budget. Nationally, 60% of Medicaid spending goes toward acute care services and over a third goes toward long-term care services.

Medicaid recipients who are disabled or elderly may also receive coverage for services such as nursing home care or home and community-based

services. Depending on the state's rules, individuals may also be asked to pay a small part of the cost (copayment) for some medical services. If an individual qualifies for both Medicare and Medicaid, most of their health care costs will be covered, including prescription drug coverage.

Frequently, nursing home residents run out of financial resources during their stay, at which point they become eligible for Medicaid coverage. States attempt to control the costs by ensuring that those receiving Medicaid benefits are truly eligible and at times adopt payment methodologies of the Medicare program. Because Medicaid programs are managed at the state level, there is state-to-state variation in eligibility requirements, coverage and reimbursement.

Medicaid reimbursement, in general, is lower than both Medicare and private insurance reimbursement. Thus, the proportion of Medicaid business for any health care organization is particularly relevant to its financial performance. Moreover, because Medicaid programs place stress on state budgets, state regulators often carry out cost containment measures to reduce Medicaid spending. State cost containment activities include the reduction of payments to providers, reduction in covered services and reduced pharmacy benefits. Over half of CAHs receive cost based reimbursement from their state Medicaid program. For information on state-specific Medicaid reimbursement rates for CAHs, please visit

<http://www.ruralcenter.org/node/159>

What is Children's Health Insurance Program (CHIP)?

The Children's Health Insurance Program (CHIP) provides access to low cost health insurance coverage for children in families who earn too much to qualify for Medicaid but not enough to be able to buy private health insurance. These families are eligible for free or low-cost health insurance that pays for doctor and dental visits as well as prescription drugs, hospitalizations and more.

GOVERNMENT HEALTH CARE REIMBURSEMENT

What is the prospective payment system?

In 1983, the payment methodology for inpatient acute hospital care (Medicare Part A) changed from cost-based reimbursement to a prospective payment system (PPS). In this new payment system, all of the various clinical diagnoses are classified into groups, called “Diagnosis Related Groups” or DRGs. With the establishment of DRG categories, of which there are more than 500, hospitals are paid a fixed amount to treat each patient based on age, sex, International Classification of Diseases (ICD) diagnoses, procedures, discharge status and the presence of comorbidities or complications. Upon admission, each patient is assigned a DRG based on his or her primary diagnosis, for example, “pneumonia”. The hospital is then paid a specific dollar amount for that pneumonia patient, based on the DRG code assigned. Some patients need more anticipated services to treat their specific ailment(s), while other cases require fewer services. Regardless, the hospital is still paid the same amount for that DRG code. Naturally, some diagnoses, and their corresponding DRGs, have very high levels of complexity and thus are more costly to treat. For example, a heart transplant is vastly more complicated and requires more resources than a normal newborn birth. Consequently, DRG reimbursement for heart transplants is higher than for the normal newborn DRG.

Base DRG rates can be adjusted for several reasons, including a hospital’s location. Just as the cost of living in the United States varies by location, the cost of providing health care varies by location as well. A heart transplant performed in San Francisco, California, would likely cost more than one performed in Omaha, Nebraska, due to wage differences, supply costs differences, etc. The DRG system adjusts for this by varying DRG payments according to market forces across the country.

Inherent in the DRG reimbursement system is the incentive for hospitals to treat and discharge patients as quickly as possible. Because this reimbursement program pays hospitals on a “per patient” basis, there is a financial incentive for hospitals to treat as many patients as possible, as efficiently as possible. By discharging patients in a timely manner, it frees more bed space which can be used to treat more incoming patients. Additionally, the reduced number of days spent in the hospital for a given patient reduces the required resources and associated costs of caring for

that patient. In this way, for any DRG, a shorter length of stay is more profitable for the hospital than a longer length of stay. Because of this direct impact on profitability, the “Average Length of Stay” metric is used by hospitals to assess the efficiency of their organization.

What is the Medicare swing bed program?

As discussed earlier, hospitals are reimbursed on a DRG basis for inpatient acute care. Often, patients who require acute inpatient services require inpatient rehabilitative aftercare or skilled nursing care. DRG acute payment rates are set based upon the resources required to treat the acute condition only, and not those expended on the subsequent rehabilitation. Therefore, the Medicare program created a separate reimbursement system to compensate providers for the extended care service they provide. The amount of extended care required by patients for any condition is highly variable because of differences in age, overall health and other factors that determine the speed of recovery. Due to this length of stay variation, hospitals receive reimbursement based on the overall assessed condition of the patient, the amount of which is determined by the assigned Resource Utilization Group (RUG).

The RUG system classifies patients into one of 66 RUG levels, based on the expected amount of provider resources to be expended. RUG payments are larger for most severe conditions that require a great deal of attention and service. In cases in which extended care is required, PPS hospitals receive two payments for a patient: DRG payment for the treatment of the acute condition and the RUG payment for care offered to patients after the acute treatment.

The Medicare swing bed program allows hospitals with 100 beds or less to provide both acute care treatment and skilled nursing treatment to patients without having to physically move the patient to another bed. The hospital receives both forms of reimbursement described above, simply by discharging patients from acute care beds and admitting them to skilled nursing beds when the patient meets the coverage guidelines for skilled care. The skilled nursing bed is sometimes referred to as a “swing” bed, because the hospital swings a bed from an acute care designation to a skilled nursing designation. Patients must be in the medically necessary acute care bed for at least 72 hours before they can be discharged to a swing bed.

What is CAH cost-based reimbursement?

During the 1980s and 1990s, almost 400 hospitals closed across the U.S. because of financial losses from the PPS system. In 1997, the Balanced Budget Act created the Medicare Rural Hospital Flexibility (Flex) Program and CAH provider type.

Medicare pays for the same services from CAHs as for other acute care hospitals (e.g., inpatient stays, outpatient visits, laboratory tests and post-acute skilled nursing days). However, CAH payments are based on each CAH's costs and the share of those costs that are allocated to Medicare patients.

CAHs receive cost based reimbursement for inpatient and outpatient services provided to Medicare patients (and Medicaid patients depending on policy of the state in which they are located). Cost based reimbursement provides significant financial advantage to CAHs by allowing them to get paid at 101% of costs on all of their hospital Medicare business. The cost of treating Medicare patients is estimated using cost accounting data from Medicare cost reports.

What is CAH Medicare ambulance Reimbursement?

Under Medicare ambulance reimbursement, if a CAH or an entity that is owned and operated by the CAH is the only provider or supplier of ambulance service located within a 35-mile drive of that CAH, the CAH or the CAH-owned and operated entity is paid 101% of the reasonable costs of the CAH or entity in furnishing ambulance services. Additionally, if there is no other provider or supplier of ambulance services within a 35-mile drive of the CAH but there is a CAH-owned and operated entity furnishing ambulance services that is more than a 35-mile drive from the CAH, that CAH-owned and operated entity can be paid 101% of reasonable costs for its ambulance services as long as it is the closest provider or supplier of ambulance services to the CAH.

What are allowable costs for 101% cost-based reimbursement from Medicare?

Medicare pays CAHs for most inpatient, outpatient and swing bed services to Medicare beneficiaries on the basis of reasonable cost. Reasonable cost is the cost that was actually incurred in order to provide a medical service, to the extent the cost is necessary in order to efficiently deliver that service.

Expenses must be prudent and reasonable, as well as related to patient care. For a condensed list of allowable vs. non allowable expenses, please refer to Table A below.

Table A. Allowable Costs in CAH

Type of Expense	Allowable or Not Allowable
Public education	Allowable
Employee recruitment	Allowable
Taxes based on income	Not Allowable
Sales tax	Allowable
Property taxes	Allowable
Entertainment	Not Allowable
Civic organizations	Allowable
Legal fees	Depends on activity
Collection agency fees	Allowable
Political/lobbying costs	Not Allowable

What is the difference between PPS and cost-based reimbursement?

PPS is a system where payment levels are set ahead of time or “prospectively” before health care services are delivered, as opposed to after the diagnosis and treatment. Because rates are set prior to services, each service has a pre-determined rate associated with it. These rates are based on estimates of the resources that must be expended for any particular service, e.g. physician time and effort, supplies, etc. In this way, this reimbursement system attempts to appropriately match payments to the acuity of patient illnesses. For example, hospitals are paid a fixed amount for performing a hip replacement and a different fixed amount for treating a patient with heart failure. This type of reimbursement methodology controls for costs because providers are paid a fixed rate per service, regardless of the costs they incur.

What is Optional (Method II) Billing?

A CAH may elect the Optional (Method II) Payment Method under which it bills the fiscal intermediary (FI) or Medicare Administrative Contractor (MAC) for both facility services and professional services to its outpatients on a single claim. Eligible medical professionals affiliated with CAHs can elect the Optional (Method II) Payment Method whereby the CAH bills on behalf of

these professionals for their outpatient services. These services include when a CAH physician reassigns outpatient billing services to the CAH, for example in pathology, radiology, emergency room, outpatient surgery and outpatient clinics. This payment does not include services provided at a rural health clinic and only applies to the CAH outpatient services.

It is important to note that Optional (Method II) Payment Method billing is setting-specific, not provider-specific. If a provider works in a rural health clinic, they cannot use Optional (Method II) Payment Method for those clinic services. However, if that same provider also provides outpatient services in the CAH, that provider could use Optional (Method II) Payment Method for those outpatient CAH services under the Optional (Method II) Payment Method based on the sum of:

- For facility services: 101% of reasonable costs, after applicable deductions, regardless of whether the physician or practitioner has reassigned his or her billing rights to the CAH; and
- For physician professional services: 115% of the allowable amount, after applicable deductions, under the Medicare Physician Fee Schedule. Payment for non-physician practitioner services is 115% of the amount that otherwise would be paid for the practitioner's professional services under the Medicare Physician Fee Schedule

Physicians reassign their billing to the hospital and the hospital must do the billing. All providers of the CAH do not need to use Optional (Method II) Payment Method, but can individually elect to do so. Overall, it is beneficial for the CAH to elect the Optional (Method II) Payment Method, as it results in higher reimbursement.

In the past, if a CAH chose to be paid under the Optional (Method II) Payment Method, it was required to make that election on an annual basis. However, in the Fiscal Year (FY) 2011 Inpatient Prospective Payment System (IPPS) Final Rule, CMS changed the regulations for the optional method election. Effective for cost reporting periods beginning on or after October 1, 2010:

- If a CAH elects the optional method in its most recent cost reporting period beginning before October 1, 2010, that election remains in place until the CAH submits a termination request to its FI/MAC. CAHs will no longer be required to make an annual election

- If a CAH chooses to make a change or terminate its optional method election, the CAH will need to notify its FI/MAC in writing at least 30 days prior to the start of the next cost reporting period

What is a Medicare Administrative Contractor (MAC)?

Section 911 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) established Medicare Contracting Reform (MCR). This statute required the Department of Health and Human Services (HHS) to replace Medicare's 48 carriers and fiscal intermediaries who process Medicare Part A and B Fee for Service claims with the new Medicare Administrative Contractor (MAC) authority. The primary reasons for instituting this change were to increase the contractor's efficiency in the receipt, processing and payment of Fee-For-Service claims. When all states are transitioned and the MACs are consolidated, there will be 10 MACs processing Part A and Part B claims.

If CAHs are reimbursed at 101%, why might they not make a profit?

Some CAH expenses, such as recruiting and bad debts, are not included in the cost-based reimbursement formula. Therefore, CAHs generally earn less than 101% of cost for care of their Medicare patients. Consequently, profitability of CAHs is dependent on private insurance business, for both inpatient and, increasingly, outpatient services. Private insurance payors do not reimburse CAHs on a cost basis, but rather follow a PPS system or reimburse on a percent of charges. In fact, the profitability of commercial business is enhanced because of the cost based reimbursement received for Medicare/Medicaid business.

Suppose a CAH administrator decides to purchase and install a CT scanner for \$1 million and assume 40% of patient care at the CAH in the CT department is Medicare business. The CAH will receive \$400,000 in cost reimbursement over the useful life of the scanner ($\$1 \text{ million} \times 40\% = \$400,000$) from Medicare for their portion of this scanner used to serve patients. This reduces the hospital's remaining costs for the CT scanner to \$600,000. The use of the scanner from other patients would need to be available in order to offset the remaining costs based on overall demand.

It is often the challenge of rural health care providers to operate profitably with a patient population that is comprised of more Medicare and Medicaid

business than urban providers. When performing financial assessments of CAHs, it is essential to evaluate both the proportion of private insurance business as well as the DRG rates negotiated with the private payor.

What is a hospital cost report?

The Medicare Cost Report is a financial document filed annually by all Medicare providers participating in the program, including: hospitals, skilled nursing facilities, home health agencies, rural health clinics (RHC), federally qualified health centers (FQHC), hospice, renal and home office. The Medicare Cost Report is submitted annually to CMS for settlement of costs relating to health care services rendered to Medicare beneficiaries. The Medicare Cost Report records: each institution's total costs and charges associated with providing services to all patients; the portion of those costs and charges allocated to Medicare patients; and the Medicare payments received.

The Medicare Cost Report must be filed with the FI/MAC within five months of fiscal year end of the CAH in order to achieve settlement of costs for health care services. Final settlement will equal the total reimbursable costs incurred by or on behalf of the CAH for furnishing covered care to the CAH's Medicare enrollees (less applicable deductible and coinsurance). Throughout the course of the year, the hospital receives interim payments from Medicare for its services. These payments are based on historical costs as claims are processed. At the end of the hospital's fiscal year, if the final settlement determination is greater than payments already made to the CAH through interim settlement, an underpayment will be declared and CMS will make a lump-sum payment to the CAH. Conversely, if the final settlement determination is less than the total payment made, the CAH has been overpaid and CMS must recover the overpayment. This is similar to the filling of individual taxes each year, where it is likely a person will either owe tax money to or be paid a refund from the state or Federal government based on estimated tax payments throughout the previous year. The above payment methodology illustrates the importance of up-to-date charges, billing and coding methodologies for the hospital to ensure accuracy and maximize allowable payment.

If a CAH has a rural health clinic attached, how do they bill for those services and file their expenses?

The primary benefit of rural health clinic (RHC) status is enhanced reimbursement from Medicare and Medicaid. Medicare reimburses RHCs based on allowable and reasonable costs. There are two types of RHCs: independent RHCs and provider based RHCs. Provider based RHCs work as a department of another provider, such as a CAH, providing health care services to the same population. Independent RHCs, on the other hand, are not affiliated with other providers. There can be significant reimbursement implications associated with each type of designation; for example, independent RHCs are subject to a payment cap, whereas provider based RHCs are not subject to a payment cap if the parent entity is a hospital with fewer than 50 available acute care beds (not licensed beds). Provider based RHCs are reported on the main provider's cost report as a department of that provider. As a result, overhead is allocated to the RHC through the step-down overhead allocation process in the same manner that impacts all of the provider's patient care service departments.

CAH FINANCES

What are the most important CAH financial indicators?

Financial indicators closely aligned with financial strength can be used to determine the financial status of a CAH. Financial indicators, often ratios, combine line items from the balance sheet, statement of operations and/or statement of cash flows in a meaningful way to help interpret strengths or weaknesses in operations or financing activities. Examining these ratios over time can help determine an organization's future trajectory or momentum.

In June 2012, a group of CAH financial experts met in Minneapolis, Minnesota at a CAH Financial Leadership Summit. Of the many identified financial ratios proven useful for assessing organizations' financial conditions, the Summit participants identified the 10 most important indicators for evaluating CAH financial performance. Table B displays each of these 10 indicators with the 2013 CAH U.S. medians as listed in the CAH Financial Indicators Reports Primer and Calculator Resources distributed by the Flex Monitoring Team in August 2015. Each indicator also notes if favorable values are trending above or below the median.

Table B. CAH Financial Indicator Medians, 2013

CAH Financial Indicator	2013 U.S. Median	Favorable Trending
Days in Accounts Receivable	54.20	Down
Days Cash on Hand	68.83	Up
Total Margin	2.51%	Up
Operating Margin	0.99%	Up
Debt Service Coverage	2.73	Up
Salaries to Net Patient Revenue	45.57%	Down
Medicare Inpatient Payor Mix*	73.01%	Down
Average Age of Plant (years)	9.77	Down
Long Term Debt to Capitalization	17.02%	Down

* Summit participants agreed Overall Payor Mix was a more comprehensive indicator of financial performance than Medicare Inpatient Payor Mix alone.

Source: Flex Monitoring Team CAH Financial Indicators Reports Primer and Calculator Resources, Template for Presentation of CAHFIR Data, August 2015.

A definition, formula and benchmarks for each of the 10 most important indicators of CAH financial performance is provided below. Each indicator also includes an example data table, which is meant to be used as a reference when calculating these ratios for a specific CAH. Sample data corresponds with the financial statements in the Appendix, including a balance sheet, statement of operations and statement of cash flows. Many of the line items on the financial statements have a letter designation under the column titled "Row". These letters are referenced in the descriptions of the indicator calculations.

Days in Net Accounts Receivable

Days in Net Accounts Receivable measures the number of days it takes an organization to collect its payments.

How values are calculated:

- Net Accounts Receivable: [Row B] – [Row C]
- Net Patient Revenue: [Row Q]
- Days in Net Accounts Receivable: $([\text{Row B}] - [\text{Row C}]) \div ([\text{Row Q}] \div 365)$

Example data:

	2013	2014	2015
Net Accounts Receivable	771,000	802,000	778,000
Net Patient Revenue	5,195,000	5,330,000	5,388,000
Days in Net Accounts Receivable	54.17	54.92	52.70

High values reflect a long collection period and indicate problems in the organization's business office with regards to billing or collecting payments. The ability to collect payments for services is increasingly difficult, but extremely important. Improvement in days in accounts receivable can mean hundreds of thousands of dollars in improvement in cash on hand. Common problems include out of date chargemasters, poor registration processes and bad communication. "Days in Accounts Receivable" is a good measure of how the billing process is working and efficiency, but it does not indicate the overall financial strength of the hospital. Favorable values are **below** the median and the 2013 CAH U.S. Median = **52.20 days**. Reductions to accounts receivable will improve cash on hand.

Days in Gross Accounts Receivable

Days in Gross Accounts Receivable tests the net days in accounts receivable with a goal of being the same amount of time as net days in accounts receivable.

How values are calculated:

- Gross Accounts Receivable: [Row B]
- Gross Revenue: [Row P]
- Days in Gross Accounts Receivable: $\text{[Row B]} \div (\text{[Row P]} \div 365)$

Example data:

	2013	2014	2015
Gross Accounts Receivable	1,001,000	1,012,000	993,000
Gross Revenue	6,395,000	6,460,000	6,503,000
Days in Gross Accounts Receivable	57.13	57.18	55.74

Days in gross accounts receivable is important to track and compare to net accounts receivable to assess the revenue cycle performance. Gross and net days are close in value in highly functioning business offices. Gross accounts receivable does not include any accounting adjustments which makes it a good measure of overall performance when compared to net days in accounts receivable. For example, if gross days are higher than net days, the organization's allowances (e.g. write offs) may require further analysis. Favorable values are **below** the median and the 2013 CAH U.S. Median = **52.20 days**.

Days Cash on Hand

Days Cash on Hand measures the number of days an organization could operate if no additional cash was collected or received. This reflects the organization's "safety net" relative to the size of the hospital's expenses.

How values are calculated:

- Cash and Temporary Investments: [Row A]
- Total Expenses: [Row X]
- Depreciation and Amortization: [Row U]
- Provision for Doubtful Accounts/Bad Debt: [Row W]
- Days Cash on Hand: $\text{[Row A]} \div ((\text{[Row X]} - \text{[Row U]} - \text{[Row W]}) \div 365)$

Note: Provision for Doubtful Accounts/Bad Debt is only included in this equation if classified as an operating expense on the Income Statement.

Example data:

	2013	2014	2015
Cash and Temporary Investments	1,120,000	1,280,000	1,831,000
Total Expenses	5,688,000	5,747,000	5,817,000
Depreciation and Amortization	229,000	218,000	211,000
Bad Debt	102,000	107,000	126,000
Days Cash on Hand	76.31	86.17	121.96

Lending organizations view this ratio as critical in the assessment of a project's feasibility, as it represents the amount of dollars readily available to meet short term obligations and make debt payments should an organization experience short term financial distress. Favorable values are **above** the median and the 2013 CAH U.S. Median = **68.83 days**.

Total Margin

Total Margin measures the control of expenses relative to revenues.

How values are calculated:

- Change in Net Assets: [Row Z]
- Total Revenue: [Row S]
- Total Margin: [Row Z] ÷ [Row S]

Example data:

	2013	2014	2015
Change in Net Assets	64,000	87,000	159,000
Total Revenue	5,752,000	5,834,000	5,976,000
Total Margin	1.11%	1.49%	2.66%

Total margin indicates the organization's overall profit. It is important to note that organizations need at least a small measure of profit to reinvest in their facilities, staff and infrastructure. Consistently negative total margins may eventually lead to hospital closure. While total margin is a good indicator of financial strength, it is important to look at operating margin as well. An organization might have a high total margin ratio if, for example, it is the recipient of non-operating sources of revenue, such as a county subsidy to provide quality health care to indigent residents. Margin driven by supplemental funding sources may be at risk with more pressure on local

and county governmental budgets, for example. Favorable values are **above** the median and the 2013 CAH U.S. Median = **2.51%**.

Operating Margin

Operating Margin measures the control of operating expenses relative to operating revenues related to patient care. Operating expenses are all expenses incurred from the hospital in delivering services. Examples are salaries and benefits, purchased services, depreciation and amortization, supplies, interest expense, professional fees and bad debt expense.

How values are calculated:

- Net Operating Income: [Row R] – [Row X]
- Total Operating Income: [Row R]
- Operating Margin: ([Row R] – [Row X]) ÷ [Row R]

Example data:

	2013	2014	2015
Net Operating Income	-7,000	10,000	63,000
Total Operating Income	5,681,000	5,757,000	5,880,000
Operating Margin	-0.12%	0.17%	1.07%

This measure reflects the overall performance on the CAH's core business: providing patient care. It is important to note that it takes into account the deductions from revenue, such as contractual allowances, bad debt and charity care. Favorable values are **above** the median and the 2013 CAH U.S. Median = **0.99%**.

Debt Service Coverage Ratio

Debt Service Coverage Ratio measures the ability to pay obligations related to long-term debt.

How values are calculated:

- Change in Net Assets: [Row Z]
- Interest: [Row V]
- Depreciation and Amortization: [Row U]
- Repayment of Debt (Principal Payments): [Row AA]
- Interest Paid on Long Term Debt (Interest Payments): [Row BB]
- Debt Service Coverage Ratio: ([Row Z] + [Row V] + [Row U]) ÷ ([Row AA] + [Row BB])

Example data:

	2013	2014	2015
Change in Net Assets	64,000	87,000	159,000
Interest	28,000	17,000	13,000
Depreciation and Amortization	229,000	218,000	211,000
Principal Payments	169,000	145,000	90,000
Interest Payments	28,000	17,000	10,000
Debt Service Coverage Ratio	1.63	1.99	3.83

The measure reflects the availability of capital after debt obligations have been satisfied. The debt service coverage represents a key ratio in determining the ability of an organization to take on additional debt, whether for information technology (IT), equipment or a building project. The higher the value of the debt service coverage ratio, the greater the “cushion” to repay outstanding debt or take on additional obligations. Favorable values are **above** the median and the 2013 CAH U.S. Median = **2.73**.

Salaries to Net Patient Revenue

Salaries to Net Patient Revenue measures labor costs relative to the generation of operating revenue from patient care.

How values are calculated:

- Salaries: [Row T]
- Net Patient Revenue: [Row Q]
- Salaries to Net Patient Revenue: [Row T] ÷ [Row Q]

Example data:

	2013	2014	2015
Salaries	2,895,000	2,908,000	2,958,000
Net Patient Revenue	5,195,000	5,330,000	5,388,000
Salaries to Net Patient Revenue	55.73%	54.56%	54.90%

Salaries are a major part of the expense structure and require close management. Reviewing the costs can help a CAH assess its staffing efficiency. Overstaffing can reduce overall hospital profitability. Closely monitoring salaries to net patient revenue and improving efficiencies can improve financial performance. Favorable values are **below** the median and the 2013 CAH U.S. Median = **45.57%**.

Payor Mix Percentage

Payor Mix Percentage is the proportion of patients represented by each payor type. As displayed below, inpatient and outpatient payor mix are calculated differently.

Inpatient Payor Mix measures the percentage of total inpatient days that are provided to patients of each payor type. The 2013 CAH U.S. Median for Medicare inpatient payor mix was **73.01%**. Favorable values are **below** the median.

$$\frac{\text{Inpatient Days for Payor}}{\text{Total Inpatient Days} - \text{Nursery Bed Days} - \text{Nursing Facility Swing Days}}$$

Outpatient Payor Mix measures the percentage of total outpatient charges that are for patients of each payor type.

$$\frac{\text{Outpatient Charges for Payor}}{\text{Total Outpatient Charges}}$$

Payor mix percentages are particularly important in estimating provider revenue, because the final reimbursement amount for any patient ultimately depends on the payment source. For CAHs, reimbursement for Medicare is 101% of costs. Real costs for Medicare patients are already below 100% since some cost, such as physician recruiting, are not reimbursed by Medicare (See Table A - "Allowable Costs in CAH"). The only alternative source of profits is providing services to privately insured patients. It is often the challenge of rural health care providers to operate profitably with a patient population that is comprised of more Medicare and Medicaid business than urban providers.

Average Age of Plant

Average Age of Plant measures the average age in years of the buildings and equipment of an organization.

How values are calculated:

- Accumulated Depreciation: [Row E]
- Depreciation and Amortization: [Row U]
- Salaries to Net Patient Revenue: [Row E] ÷ [Row U]

Example data:

	2013	2014	2015
Accumulated Depreciation	1,874,000	1,755,000	1,896,000
Depreciation Expense	229,000	218,000	211,000
Average Age of Plant	8.18	8.05	8.99

CAHs often fail to improve or rebuild their facilities. The status of newer facilities has been shown to have a positive effect on financial performance and on the recruitment and retention of physicians and staff. Average age of plant is a good indicator of distress with older hospitals having greater problems. Lower, decreasing values indicate a newer facility or more frequent reinvestments in buildings or equipment over time. Favorable values are **below** the median and the 2013 CAH U.S. Median = **9.77 years**.

Long Term Debt to Capitalization

Long Term Debt to Capitalization measures the percentage of net assets (or equity) that is debt.

How values are calculated:

- Long Term Debt, Net of Current Portion: [Row K]
- Net Assets - Accumulated Earnings (Deficit): [Row M]
- Long Term Debt to Capitalization: [Row K] ÷ ([Row K] + [Row M])

Example data:

	2013	2014	2015
Long Term Debt	186,000	183,000	178,000
Net Assets	1,835,000	2,173,000	2,694,000
Long Term Debt to Capitalization	9.20%	7.77%	6.20%

This ratio measures the amount of capital that is financed with debt, which is important to lenders for long term viability. Higher values signify a riskier

situation and indicate that a hospital may have a harder time sustaining debt payments in the future and/or getting financing from lenders. Favorable values are **below** the median and the 2013 CAH U.S. Median = **17.02%**.

Is there a model for predicting CAH financial distress?

The CAH Financial Distress Model was developed by researchers from the North Carolina Rural Health Research and Policy Analysis Center at University of North Carolina at Chapel Hill. A well-functioning prediction model, such as this, can be used as an early warning system to identify hospitals at increased risk of facing financial distress. State Medicare Flex Programs, CAH CEOs and boards reviewing the model could identify areas of particular distress and develop strategies, or interventions, to improve financial performance.

Today's characteristics (recent financial performance and measures of a market in which a hospital operates) are used to assign CAHs to one of four "risk levels" that predict whether a CAH will be in financial distress two years later. Many financial performance and market characteristics were considered for inclusion. The final model was selected due to its ability to predict performance in a straightforward manner. Variables used in the model are noted below in Tables C, D and E.

The model separates hospitals into risk of financial distress categories; hospitals in the highest risk category had up to 15 times the rate of financial distress events as hospitals in the lowest category. Financial distress events include:

- Closure
- Negative fund balance
- Declining (>25%) fund balance
- Three years negative operating margin
- Negative cash flow margin

Accurate assignment of hospitals to categories that reflect low, mid-low, mid-high and high risk of financial distress can provide an effective early warning system to CAHs, allowing CAH Administrators and state Medicare Flex Program Coordinators to target efforts to those at higher risk.

Table C. Descriptive Measures of Variables Included in CAH Financial Distress Model, Financial Performance

Variable	Description
Profitability	Earnings before interest and taxes divided by total assets, operating margin and the 2-year change in operating margin
Reinvestment	Retained earnings divided by total assets
Hospital Size	Net patient revenue

Table D. Descriptive Measures of Variables Included in CAH Financial Distress Model, Market Characteristics

Variable	Description
Competition	Distance to the nearest hospital with at least 100 beds and percent market share, if less than 25 percent
Economic Status	Percent unemployment in the market area
Market Size	Population in the market area

Table E. Descriptive Measures of Variables Included in CAH Financial Distress Model, Financial Distress Signals

Variable	Description
Equity Decline	Whether the fund balance declined more than 25% and whether the fund balance was negative
Unprofitability	Indicator variables for a negative cash flow margin and three consecutive years of negative operating margin
Closure	Whether the hospital closed

Where can I find information about the financial performance of CAHs in my state?

A “CAH Financial Indicators Report (CAHFIR)”, produced by the Flex Monitoring Team, is provided to individual CAHs late each summer with a summary report for the state provided to the state Flex Programs. These reports include a variety of metrics and will now include the Financial Distress Model. The CAHFIRs also allow CAHs to compare their financial performance to peer facilities. For more information visit <http://www.flexmonitoring.org/publications/annual-financial-indicator-reports/>

The Flex Monitoring Team has also released primers, a presentation template and a calculator spreadsheet to support the CAHFIRs. The primer documents introduce the CAHFIR, explain the measure calculations and offer insights regarding the roles each measure plays in assessing a hospital's financial health. The presentation temple is an editable PowerPoint file for CAHs to use in presenting their won CAHFIR data to others. The calculator spreadsheet is an Excel file that enables CAHs to verify the Flex Monitoring Team's calculations and also calculate more recent financial indicators using data on hand. For more information visit

<http://www.flexmonitoring.org/publications/cahfir-resources/>

IMPROVING CAH FINANCIAL PERFORMANCE

What interventions can CAHs use to improve their financial performance?

The 2012 CAH Financial Leadership Summit identified a number of important financial interventions that historically have been associated with improved financial performance. They include:

- Cost report review and strategy
- Strategic, financial and operational assessments
- Revenue cycle management
- Physician practice management assessments
- Lean process improvement training
- Financial education for CAH department managers
- Financial education for CAH boards
- Pooling Small Rural Hospital Improvement Program (SHIP) dollars
- Developing chief financial officer (CFO) networks
- Benchmarking financial indicators

Why is a review of the cost report important?

A review of the cost report can be completed by an outside party to look for common errors in preparation. Because it drives Medicare payments, errors on the cost report directly affect the bottom line, sometimes as much as hundreds of thousands of dollars. Errors include incorrect allocations of expenses and inaccurate statistics, for example. Most cost reports are "outsourced," but understanding direct and indirect costs and how cost reports work is a critical input to making sound decisions for chief executive officers (CEOs), CFOs and board members.

What is a Chargemaster and how often should it be reviewed?

The Charge Description Master (CDM) is primarily a list of services and procedures, room accommodations, supplies, drugs/biologics and/or radiopharmaceuticals that may be billed to a patient registered as an inpatient or outpatient on a claim. It is integral to the CAH's revenue cycle and provides many of the necessary data elements for compliant claims submission for reimbursement. It is recommended to have an outside source perform a comprehensive chargemaster and revenue cycle review annually. Ongoing education is also crucial to having business office staff remain current with information necessary to appropriately bill for services rendered. Code changes and description changes must be communicated to the departments who will be generating the charges and may need to be altered or added to the system. Similarly, charge tickets may need to be updated. Billing and coding workshops are available in many locations throughout the country. For information on upcoming workshops and trainings visit

http://www.ruralcenter.org/search/apachesolr_search?filters=tid%3A2%20type%3Aeducation_gateway&solrsort=created%20desc&retain-filters=1

What are strategic, financial and operational assessments?

Strategic, financial and operational assessments provide a broad-based analysis of hospital performance and help identify specific opportunities for CAH improvement. These studies provide an objective review of the areas where many CAHs need help, including:

- Matching services to community needs
- Staffing to benchmarks
- Clinic management
- Medical staff planning
- Organizational culture

Assessments are recommended periodically to determine areas of focus for follow-up improvement work.

What is revenue cycle management?

Revenue cycle management is a means to improve hospital revenue and reimbursement by streamlining workflow, processes and education throughout all financial components of the hospital. A holistic revenue cycle management includes a multi-disciplinary approach focusing on culture

change with comprehensive, dramatic and permanent results. Specific areas of focus may include:

- Comprehensive chargemaster and revenue cycle review
- Business office and patient financial services review
- Development of training protocols for revenue capture
- Implementation of an effective revenue control process
- Pricing analysis
- Recovery audit contractor (RAC) preparedness and revenue cycle process improvement
- Revenue process capture audits

These assessments should result in identifying opportunities for improvement and specific, actionable recommendations.

Why are physician practice management assessments useful?

As more and more physicians align and become employees of CAHs, it is critically important to contract with physicians and operate clinics according to best practices. A practice management assessment looks at physician and mid-level provider productivity, scheduling, staffing, billing and collection practices. These assessments should result in specific recommendations and action plans that have the potential to bring in additional revenue and improve clinic efficiency.

What is Lean and how can it impact CAH finances?

Lean focuses on increasing efficiency and eliminating waste. This creates greater value for customers and uses fewer resources. In the health care setting, Lean processes can result in substantial cost savings, fewer delays and increased patient and staff satisfaction. Lean education, Lean networks and shared Lean expertise have all been successfully used by individual CAHs and networks of rural hospitals.

Why is education on finances important for CAH department managers and Board members?

Financial education for CAH department managers can enhance budgeting, planning and financial skills in department heads, whose background may be clinical rather than business or administrative. CAH Board members similarly lack basic CAH financial knowledge. Financial education for CAH Boards provides a fundamental grounding on cost-based reimbursement and CAH

financial strategies. Hospital financial management is complex and rural hospital boards need a basic understanding of CAH finances to provide needed oversight. This type of education has been done successfully with rural hospitals using both on-site workshops and web-based presentations, which are often stored and accessible online.

Why is collaboration important for improving finances in CAHs?

Two minds are better than one. Collaboration allows CAH staff to share ideas, lessons learned, best practices and funds with one another. Many state Flex Programs have provided support to develop CFO networks. CFO networks have proven to be a popular method of education, peer learning and peer support. In more than a dozen states, rural hospital CFOs meet periodically, either in person or virtually, to discuss common issues, gain new skills and share experiences and techniques.

Benchmarking financial outcomes among groups of hospitals is a common means of measuring performance and comparing results. By collaboratively comparing results, CAHs identify areas of strengths and weaknesses and measure progress toward strategic goals. This collective benchmarking also provides an opportunity for the hospitals to share common issues, best practices and lessons learned. The University of North Carolina-Chapel Hill's distribution of an annual CAH Financial Indicators Report is a useful source for benchmarking, but other information sources are also available.

Aside from the value of bringing collective minds together, using various funding sources to achieve an end goal can be strategic. Pooling SHIP dollars among a group of CAHs has provided an effective means of providing financial or Lean education to hospital staff and boards. Economies of scale, shared expertise, access to speakers and resources, peer learning and support have all been reported as benefits of pooling resources.

APPENDIX

Example Critical Access Hospital – Balance Sheet

[Row]		2013	2014	2015
	ASSETS			
	Current Assets:			
A	Cash and Temporary Investments	1,120,000	1,280,000	1,831,000
B	Patient Accounts Receivable, Gross	1,001,000	1,012,000	993,000
C	Less: Provision for Doubtful Accounts	-230,000	-210,000	-215,000
	Other Accounts Receivable	-	24,000	24,000
	Supplies	162,000	169,000	169,000
	Other Current Assets	68,000	57,000	57,000
D	Total Current Assets	2,121,000	2,332,000	2,859,000
	Property, Plant & Equipment:	2,663,000	2,612,000	2,712,000
E	Less: Accumulated Depreciation	-1,874,000	-1,755,000	-1,896,000
	Net Fixed Assets	789,000	857,000	816,000
F	TOTAL ASSETS	2,910,000	3,189,000	3,675,000
	LIABILITIES & NET ASSETS			
	Current Liabilities:			
G	Current Portion of Long Term Debt	144,000	89,000	49,000
H	Accounts Payable & Accrued Liabilities	115,000	148,000	158,000
	Estimated Amounts Due to Third Party	260,000	226,000	226,000
I	Other Current Liabilities	370,000	370,000	370,000
J	Total Current Liabilities	889,000	833,000	803,000
K	Long Term Debt, Net of Current Portion	186,000	183,000	178,000
L	TOTAL LIABILITIES	1,075,000	1,016,000	981,000
	NET ASSETS			
M	Accumulated Earnings (Deficit)	1,835,000	2,173,000	2,694,000
	TOTAL LIABILITIES & NET ASSETS	2,910,000	3,189,000	3,675,000

Example Critical Access Hospital – Statement of Operations

[Row]		2013	2014	2015
	REVENUE			
N	Total Inpatient Revenue	2,402,000	2,445,000	2,471,000
O	Total Outpatient Revenue	3,993,000	4,015,000	4,032,000
P	Total Gross Revenue	6,395,000	6,460,000	6,503,000
	Less: Contractual Allowances	-1,200,000	-1,130,000	-1,115,000
Q	Net Patient Revenue	5,195,000	5,330,000	5,388,000
	Other Operating Revenue	486,000	427,000	492,000
R	Total Operating Revenue	5,681,000	5,757,000	5,880,000
	Gain (Loss) on PP&E Disposal	-2,000	-3,000	-
	Contributions/Grants	65,000	69,000	77,000
	Investment Income	8,000	11,000	19,000
S	Total Revenue	5,752,000	5,834,000	5,976,000
	EXPENSES			
T	Salaries	2,895,000	2,908,000	2,958,000
	Benefits, Supplies & Other	2,434,000	2,497,000	2,509,000
U	Depreciation & Amortization	229,000	218,000	211,000
V	Interest	28,000	17,000	13,000
W	Provision for Doubtful Accounts/Bad Debt	102,000	107,000	126,000
X	Total Expenses	5,688,000	5,747,000	5,817,000
Y	EXCESS OF REVENUES OVER EXPENSES	64,000	87,000	159,000
	Restricted Contributions	-	-	-
Z	CHANGE IN NET ASSETS	64,000	87,000	159,000

Example Critical Access Hospital – Statement of Cash Flows

[Row]		2013	2014	2015
	CASH FLOWS FROM OPERATING ACTIVITIES			
	Change in Net Assets	522,000	547,000	542,000
	Adjustments to reconcile change in net cash provided by operating activities:			
	Purchase of Other Assets	246,000	459,000	-210,000
	Other Current Liabilities	-3,000	-6,000	-
		34,000	-	-
	Net Cash Provided by Operating Activities	799,000	1,000,000	332,000
	CASH FLOWS FROM FINANCING ACTIVITIES			
AA	Repayment of Debt	-169,000	-145,000	-90,000
	Purchase of PP&E	-63,000	-189,000	-100,000
BB	Interest Paid on Long Term Debt	-28,000	-17,000	-10,000
	Gifts to Purchase Capital Assets	46,000	-	-
	Net Cash Used by Investing Activities	-214,000	-351,000	-200,000
	CASH FLOWS FROM INVESTING ACTIVITIES			
	Interest and Dividends on Investments	8,000	11,000	19,000
	Net Cash Used by Investing Activities	8,000	11,000	19,000
	NET INCREASE (DECREASE) IN CASH	593,000	660,000	151,000
	CASH, BEGINNING OF YEAR	527,000	1,120,000	1,178,000
	CASH, END OF YEAR	1,120,000	1,780,000	1,931,000

VIII. Appendix C

Integration of Innovative Health Care Models

Integration of Innovative Health Care Models

This program area focuses on developing and integrating innovative health care models around the areas of quality, financial/operations, population health and/or system delivery in rural communities. Ideally, successful models will improve care in rural areas and serve as best practices or strategies for other states.

Note: Funds cannot be used to support Patient Centered Medical Home (PCMH) certification. (See also viii. Grant Budget pg. 7)

All funds must be expended in year one. The grantee is expected to document significant progress against a set target measure, but it is understood that many of these activities cannot be completed in one year. For example, an improvement activity might be planned and implemented in year one, and assessed in year two to determine if the activity was successful.

Proposed projects must include clear methodology and clear and measurable outcomes to support the financial and operational transition to value based models and health care transformation models in the health care system.

Flex funds can be used to assess the impact or support the implementation of health care system changes that will have a substantial effect on quality, financial and operational performance, population health management, or Emergency Medical Systems (EMS) integration of CAHs. A project in this category must include proposed objectives, activities, and desired outcomes.

Objective: To develop/implement innovative health care models designed to have a positive transformational impact on rural health.

Activity: Integration of Innovative Health Care Models

Specific areas of focus may include:

- Clinically integrated networks
- Population Health Management
- Projects addressing frequent/high cost users of health care or emergency department
- Care Coordination

Measures for Activity: Specific outcome measures must be identified so that progress can be measured throughout the project. Applicants must clearly identify proposed projects and measures.